

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,160	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			3,819	3,819	8
9	SNF/PED					9
10	ICF	36,276	3,087	2,987	42,350	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,276	3,087	6,806	46,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.74%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 09/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/87 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 3,819

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	211,861	2,599	8,686	223,146		223,146		223,146		1
2	Food Purchase		201,092		201,092		201,092	(335)	200,757		2
3	Housekeeping	214,984	49,030		264,014		264,014	613	264,627		3
4	Laundry	64,029	34,522	324	98,875		98,875		98,875		4
5	Heat and Other Utilities			120,694	120,694		120,694	1,863	122,557		5
6	Maintenance	62,045	27,251	19,394	108,690		108,690	430	109,120		6
7	Other (specify):*			7,364	7,364		7,364		7,364		7
8	TOTAL General Services	552,919	314,494	156,462	1,023,875		1,023,875	2,571	1,026,446		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	1,528,373	107,303	45,593	1,681,269		1,681,269	22,679	1,703,948		10
10a	Therapy	52,353	2,696	3,870	58,919		58,919		58,919		10a
11	Activities	172,260	2,031	313	174,604		174,604		174,604		11
12	Social Services	38,146		3,046	41,192		41,192		41,192		12
13	Nurse Aide Training										13
14	Program Transportation			58	58		58		58		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,791,132	112,030	66,880	1,970,042		1,970,042	22,679	1,992,721		16
	C. General Administration										
17	Administrative	116,666		61,488	178,154		178,154	3,121	181,275		17
18	Directors Fees										18
19	Professional Services			97,339	97,339		97,339	(38,079)	59,260		19
20	Dues, Fees, Subscriptions & Promotions			95,064	95,064		95,064	(18,329)	76,735		20
21	Clerical & General Office Expenses	161,776	34,692	183,327	379,795		379,795	(97,390)	282,405		21
22	Employee Benefits & Payroll Taxes			402,454	402,454		402,454	30,757	433,211		22
23	Inservice Training & Education			1,040	1,040		1,040		1,040		23
24	Travel and Seminar			12,919	12,919		12,919	3,058	15,977		24
25	Other Admin. Staff Transportation			74,313	74,313		74,313	5,572	79,885		25
26	Insurance-Prop.Liab.Malpractice			138,472	138,472		138,472	2,266	140,738		26
27	Other (specify):* BAD DEBT			9,465	9,465		9,465	(9,465)			27
28	TOTAL General Administration	278,442	34,692	1,075,881	1,389,015		1,389,015	(118,489)	1,270,526		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,622,493	461,216	1,299,223	4,382,932		4,382,932	(93,239)	4,289,693		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

GLENWOOD HEALTHCARE & REHAB

#0032839

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			50,146	50,146		50,146	168,758	218,904			30
31	Amortization of Pre-Op. & Org.							24,533	24,533			31
32	Interest			17,213	17,213		17,213	493,181	510,394			32
33	Real Estate Taxes			457,191	457,191		457,191		457,191			33
34	Rent-Facility & Grounds			726,112	726,112		726,112	(718,827)	7,285			34
35	Rent-Equipment & Vehicles			3,372	3,372		3,372	359	3,731			35
36	Other (specify):* STORAGE			1,950	1,950		1,950		1,950			36
37	TOTAL Ownership			1,255,984	1,255,984		1,255,984	(31,996)	1,223,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,969	161,735	238,704		238,704		238,704			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			100,740	100,740		100,740		100,740			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		76,969	262,475	339,444		339,444		339,444			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,622,493	538,185	2,817,682	5,978,360		5,978,360	(125,235)	5,853,125			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,067)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(335)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,542)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,465)	27		24
25	Fund Raising, Advertising and Promotional	(15,068)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	(41,277)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,754)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46,481)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,481)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (125,235)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

GLENWOOD HEALTHCARE & REHAB

ID# 0032839

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 336	6	1
2	MARKETING SALARY	(41,613)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(41,277)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB# 0032839

Report Period Beginning:

01/01/2002

Ending:

12/31/2002**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(335)	0	0	0	0	0	0	0	0	0	0	(335)	2
3	Housekeeping	0	0	613	0	0	0	0	0	0	0	0	613	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,863	0	0	0	0	0	0	0	0	1,863	5
6	Maintenance	336	0	94	0	0	0	0	0	0	0	0	430	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1	0	2,570	0	2,571	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	22,679	0	0	0	0	0	0	0	0	22,679	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	22,679	0	22,679	16							
	C. General Administration													
17	Administrative	0	(61,488)	64,609	0	0	0	0	0	0	0	0	3,121	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(44,255)	6,176	0	0	0	0	0	0	0	0	(38,079)	19
20	Fees, Subscriptions & Promotions	(18,610)	0	281	0	0	0	0	0	0	0	0	(18,329)	20
21	Clerical & General Office Expenses	(41,613)	(158,345)	102,568	0	0	0	0	0	0	0	0	(97,390)	21
22	Employee Benefits & Payroll Taxes	0	0	30,757	0	0	0	0	0	0	0	0	30,757	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,058	0	0	0	0	0	0	0	0	3,058	24
25	Other Admin. Staff Transportation	0	0	5,572	0	0	0	0	0	0	0	0	5,572	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,266	0	0	0	0	0	0	0	0	2,266	26
27	Other (specify):*	(9,465)	0	0	0	0	0	0	0	0	0	0	(9,465)	27
28	TOTAL General Administration	(69,688)	(264,088)	215,287	0	(118,489)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,687)	(264,088)	240,536	0	(93,239)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB# 0032839

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(9,067)	174,844	2,981	0	0	0	0	0	0	0	0	168,758	30
31	Amortization of Pre-Op. & Org.	0	24,533	0	0	0	0	0	0	0	0	0	24,533	31
32	Interest	0	493,179	2	0	0	0	0	0	0	0	0	493,181	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(726,112)	7,285	0	0	0	0	0	0	0	0	(718,827)	34
35	Rent-Equipment & Vehicles	0	0	359	0	0	0	0	0	0	0	0	359	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,067)	(33,556)	10,627	0	(31,996)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,754)	(297,644)	251,163	0	(125,235)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SCHEDULE ATTACHED		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BOOKEEPING/MANAGEMENT
RITA L. GELLER	38.04					
JOSEPH C. CHOW	39.13			GLENWOOD TERRACE LLC	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17 MANAGEMENT FEES	\$ 61,488	CERTIFIED HEALTH MANAGEMENT		\$	\$ (61,488)	1
2	V	21 BOOKKEEPING	160,789				(160,789)	2
3	V	19 ADMIN.CONSULTANT FEES	44,255				(44,255)	3
4	V							4
5	V							5
6	V							6
7	V	34 RENT	726,112	GLENWOOD TERRACE LLC			(726,112)	7
8	V	30 DEPRECIATION		" " "		174,844	174,844	8
9	V	31 AMORTIZATION		" " "		24,533	24,533	9
10	V	32 INTEREST		" " "		493,179	493,179	10
11	V	21 OFFICE EXP		" " "		2,444	2,444	11
12	V							12
13	V							13
14	Total		\$ 992,644			\$ 695,000	\$ * (297,644)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 613	\$ 613	15
16	V	5 ELECTRIC & GAS		" " "		1,863	1,863	16
17	V	6 MAINTENANCE		" " "		94	94	17
18	V	10 NURSING/MEDICAL RECORDS		" " "		22,679	22,679	18
19	V	17 ADMIN SALARIES		" " "		64,609	64,609	19
20	V	19 PROFESSIONAL FEES		" " "		6,176	6,176	20
21	V	20 FEE, SUBSCRIPTIONS		" " "		281	281	21
22	V	21 OFFICE EXP.		" " "		102,568	102,568	22
23	V	22 EMPLOYEE BENEFITS		" " "		30,757	30,757	23
24	V	24 TRAVEL/SEMINAR		" " "		3,058	3,058	24
25	V	25 TRANSPORTATION		" " "		5,572	5,572	25
26	V	26 INSURANCE		" " "		2,266	2,266	26
27	V	30 DEPRECIATION		" " "		2,981	2,981	27
28	V	32 INTEREST		" " "		2	2	28
29	V	34 OFFICE RENT		" " "		7,285	7,285	29
30	V	35 EQUIPMENT RENTAL		" " "		359	359	30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 251,163	\$ * 251,163	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE		NONE			SALARY	\$ 57,752	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 57,752		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB

0032839

Report Period Beginning: 01/01/2002

Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CERTIFIED HEALTH MANAGEMENT
 Street Address 3856 OAKTON SUTIE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	272,818	8	\$ 3,625	\$ 46,169	\$ 613	1
2	5	ELECTRIC & GAS	" " "	272,818	8	11,011	46,169	1,863	2
3	6	MAINTENANCE	" " "	272,818	8	557	46,169	94	3
4	10	NURSING/MEDICAL RECORD	" " "	272,818	8	134,010	134,010	22,679	4
5	17	ADMIN SALARIES	" " "	272,818	8	381,783	381,783	64,609	5
6	19	PROFESSIONAL FEES	" " "	272,818	8	36,495	46,169	6,176	6
7	20	FEE, SUBSCRIPTIONS	" " "	272,818	8	1,662	46,169	281	7
8	21	OFFICE EXP.	" " "	272,818	8	606,084	496,771	102,568	8
9	22	EMPLOYEE BENEFITS	" " "	272,818	8	181,747	46,169	30,757	9
10	24	TRAVEL/SEMINAR	" " "	272,818	8	18,072	46,169	3,058	10
11	25	TRANSPORTATION	" " "	272,818	8	32,928	46,169	5,572	11
12	26	INSURANCE	" " "	272,818	8	13,389	46,169	2,266	12
13	30	DEPRECIATION	" " "	272,818	8	17,618	46,169	2,981	13
14	32	INTEREST	" " "	272,818	8	9	46,169	2	14
15	34	OFFICE RENT	" " "	272,818	8	43,046	46,169	7,285	15
16	35	EQUIPMENT RENTAL	" " "	272,818	8	2,124	46,169	359	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,484,160	\$ 1,012,564	\$ 251,163	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization GLENWOOD TERRACE LLC
 Street Address 3856 OAKTON, SUITE 200
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847) 674-4700
 Fax Number (847) 674-4733

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	30	DEPRECIATION	DIRECT COST	1	174,844		1	174,844	2
3	31	AMORTIZATION	DIRECT COST	1	24,533		1	24,533	3
4	32	INTEREST	DIRECT COST	1	493,179		1	493,179	4
5	21	OFFICE EXP	DIRECT COST	1	2,444		1	2,444	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,000	\$		\$ 695,000	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	BARRY KIRSCHENBAUM	X		MORTGAGE	\$48,244.00	1/1/99	\$ 5,796,000	\$ 5,501,702	1/1/24	8.9000	\$ 493,179	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND					PRIME +	14,649	6								
7	INS FINANCING		X								2,564	7								
8	RELATED PARTY	X									2	8								
9	TOTAL Facility Related				\$48,244.00		\$ 5,796,000	\$ 5,501,702			\$ 510,394	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 5,796,000	\$ 5,501,702			\$ 510,394	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		\$	410,758	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	430,062	2
3. Under or (over) accrual (line 2 minus line 1).		\$	19,304	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	438,663	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 776 For 1995 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(776)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	457,191	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	345,013		8
	1998	351,119		9
	1999	392,834		10
	2000	402,704		11
	2001	430,062		12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.				
FOR OHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD HEALTHCARE & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 X40 FAX #: (847) 674-4733

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>32-10-201-009-000</u>	<u>NURSING HOME</u>	\$ <u>430,062.00</u>	\$ <u>430,062.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>430,062.00</u>	\$ <u>430,062.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>		<u>1999</u>	\$ <u>322,000</u>	1
2					2
3	TOTALS			\$ 322,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	184		1999		\$ 5,474,000	\$ 140,359	39	\$ 140,359	\$ (0)	\$ 561,436	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LEASEHOLD IMPROVEMENTS	1988		20,662	656	30	689	33	9,679	9
10		LEASEHOLD IMPROVEMENTS	1989		4,071	129	30	136	7	1,836	10
11		LEASEHOLD IMPROVEMENTS	1990		28,171	894	30	939	45	11,738	11
12		LEASEHOLD IMPROVEMENTS	1991		31,712	1,007	30	1,057	50	12,156	12
13		LEASEHOLD IMPROVEMENTS	1992		10,071	320	30	336	16	3,528	13
14		LEASEHOLD IMPROVEMENTS	1993		4,810	153	30	160	7	1,583	14
15		LEASEHOLD IMPROVEMENTS	1994		17,744		5			17,744	15
16		LIGHT FIXTURES, ROOM SIGNS, HAND RAILS	1995		6,343	163	39	163	(0)	1,438	16
17		HEATING/AIR CONDITIONING	1995		12,515	321	39	321	(0)	2,822	17
18		NURSING STATION	1995		10,384	266	39	266	0	2,250	18
19		SPRINKLER/LAUDRY VENTILATION REPAIR	1995		2,360	61	39	61	(0)	502	19
20		LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER	1996		3,650	94	39	94	(0)	719	20
21		EXIT & OUTDOOR SIGNS	1996		4,237	109	39	109	(0)	809	21
22		WINDOWS, DOORS, CEILING TILES/CARPET	1996		25,090	643	39	643	0	4,632	22
23		HVAC WIRING REPAIR	1996		1,540	39	39	39	0	284	23
24		TIME CLOCKS,HEAT & COOL UNITS	1997		7,022	180	39	180	0	998	24
25		NURSE STATION	1997		5,615	144	39	144	(0)	798	25
26		FLOOR/CEILING TILES, COUNTER & CABINETS	1997		21,659	555	39	555	0	3,150	26
27		DOORS, LIGHTS, SIGNNS	1997		14,825	380	39	380	0	2,178	27
28		BURNERS & ELECTRICAL FOR WASHER	1997		1,964	50	39	50	0	277	28
29		SIGNS, PATIO SURFACE	1998		6,994	466	15	466	0	2,097	29
30		WINDOWS & INSTALLATION	1998		18,944	486	39	486	(0)	2,410	30
31		KITCHEN REMODEL	1998		50,500	1,295	39	1,295	(0)	6,423	31
32		ELECTRIC WORK	1998		7,545	193	39	193	0	877	32
33		CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD	1998		79,382	2,035	39	2,035	0	8,672	33
34		GENERATOR	1999		56,533	1,450	39	1,450	(0)	5,741	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	HEAT AND AIR CONDITIONER	1999	\$ 14,673	\$ 376	39	\$ 376	\$ 0	\$ 1,332	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141	0	488	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522	0	5,138	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868	1,410	7	1,410	(0)	5,237	40
41	ROOF REPAIR	2000	3,750	136	27.5	136	0	380	41
42	VINYL TILE/COVE BASE	2000	19,277	701	27.5	701	(0)	1,889	42
43	ALARM WORK	2000	3,848	140	27.5	140	(0)	306	43
44	DRAPERIES	2001	1,750	64	27.5	64	(0)	120	44
45	ELECTRICAL WORK	2001	5,550	202	27.5	202	(0)	328	45
46	TILE	2002	13,079	179	27.5	238	59	179	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,065,003	\$ 157,319		\$ 157,536	\$ 217	\$ 682,174	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 217,388	\$ 23,666	\$ 21,739	\$ (1,927)	10 YRS	\$ 205,375	71
72	Current Year Purchases	21,637	9,520	2,164	(7,356)	5 YRS	9,520	72
73	Fully Depreciated Assets	196,314					4,850	73
74	RELATED PARTY		37,466	37,466				74
75	TOTALS	\$ 435,339	\$ 70,652	\$ 61,369	\$ (9,284)		\$ 219,745	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,822,342	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 227,971	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 218,904	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,067)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 901,919	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. 2003 \$ _____

13. 2004 \$ _____

14. 2005 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,372

Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	85,329	\$		\$	85,329	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,155				2,155	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				74,251				74,251	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-2	# of prescripts					61,105			61,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	MEDICAL SUPPLIES Other (specify):	39-2						15,864			15,864	13
14	TOTAL			\$		\$	161,735	\$	76,969	\$	238,704	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **GLENWOOD HEALTHCARE & REHAB**# **0032839**Report Period Beginning: **01/01/2002**

Ending:

12/31/2002**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2002**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 82,000)	310,366		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,984		6
7	Other Prepaid Expenses	2,933		7
8	Accounts Receivable (owners or related parties)	398,524		8
9	Other(specify): real estate escrow	214,138		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 963,945	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	591,004		15
16	Equipment, at Historical Cost	435,339		16
17	Accumulated Depreciation (book methods)	(481,680)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 544,663	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,508,608	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 181,269	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,000		28
29	Short-Term Notes Payable	56,321		29
30	Accrued Salaries Payable	145,894		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,888		31
32	Accrued Real Estate Taxes(Sch.IX-B)	438,663		32
33	Accrued Interest Payable	39		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 847,074	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 847,074	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 661,534	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,508,608	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 624,717	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 624,717	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	\$ 36,817	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 36,817	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 661,534	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,930,958	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,930,958	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	81,365	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 81,365	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	685	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 685	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	5,287	28
28a	VENDING COMMISSIONS	3,382	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,669	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,021,677	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,023,875	31
32	Health Care	1,970,042	32
33	General Administration	1,389,015	33
B. Capital Expense			
34	Ownership	1,255,984	34
C. Ancillary Expense			
35	Special Cost Centers	238,704	35
36	Provider Participation Fee	100,740	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,978,360	40
41	Income before Income Taxes (line 30 minus line 40)**	43,317	41
42	Income Taxes	6,500	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,817	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,415	1,415	\$ 33,412	\$ 23.61	1
2	Assistant Director of Nursing	1,622	1,622	29,463	18.16	2
3	Registered Nurses	6,137	6,177	137,570	22.27	3
4	Licensed Practical Nurses	25,094	25,350	476,185	18.78	4
5	Nurse Aides & Orderlies	90,067	92,272	814,764	8.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,801	4,041	52,353	12.96	8
9	Activity Director	2,392	2,480	34,072	13.74	9
10	Activity Assistants	14,893	15,713	138,188	8.79	10
11	Social Service Workers	2,994	3,178	38,146	12.00	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,080	36,367	17.48	13
14	Head Cook	3,500	4,012	40,324	10.05	14
15	Cook Helpers/Assistants	18,235	19,326	135,170	6.99	15
16	Dishwashers					16
17	Maintenance Workers	4,655	4,711	62,045	13.17	17
18	Housekeepers	27,135	28,467	214,984	7.55	18
19	Laundry	8,513	9,161	64,029	6.99	19
20	Administrator	1,160	1,200	34,737	28.95	20
21	Assistant Administrator	4,008	4,160	81,929	19.69	21
22	Other Administrative					22
23	Office Manager	4,080	4,160	62,182	14.95	23
24	Clerical	6,063	6,303	57,981	9.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,243	3,515	28,979	8.24	31
32	Other Health C: CARE PLAN	539	539	8,000	14.84	32
33	Other(specify) MARKETING	2,682	2,682	41,613	15.52	33
34	TOTAL (lines 1 - 33)	234,212	242,564	\$ 2,622,493 *	\$ 10.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	185	\$ 8,351	1-3	35
36	Medical Director	monthly	14,000	9-3	36
37	Medical Records Consultant	223	8,952	10-3	37
38	Nurse Consultant	35	1,731	10-3	38
39	Pharmacist Consultant	monthly	1,115	10-3	39
40	Physical Therapy Consultant	80	3,572	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	5	298	10a-3	43
44	Activity Consultant	10	313	11-3	44
45	Social Service Consultant	88	3,046	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	626	\$ 41,378		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	180	\$ 7,505	10-3	50
51	Licensed Practical Nurses	250	9,214	10-3	51
52	Nurse Aides	495	12,385	10-3	52
53	TOTAL (lines 50 - 52)	925	\$ 29,104		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year								
					5 FY1999	6 FY2000	7 FY2001	8 FY2002	9 FY2003	10 FY2004	11 FY2005	12 FY2006	13 FY2007
					1	PAINTING/DECORATING	1999	\$ 2,031	3	\$ 355	\$ 670	\$ 670	\$ 336
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,031		\$ 355	\$ 670	\$ 670	\$ 336	\$	\$	\$	\$	\$

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB# 0032839Report Period Beginning: 01/01/2002Ending: 12/31/2002**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LTC \$ 6,922
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 100,740
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,351
	REPAIRS & MAINTENANCE	335
		0
		8,686
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	324
		0
		324
5	HEAT & OTHER UTILITIES	
	GAS HEAT	28,322
	ELECTRICITY	66,298
	WATER	26,074
	CABLE TV - LOBBY	0
		0
		120,694
6	MAINTENANCE	
	GROUNDS MAINTENANCE	8,377
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,646
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,336
	FIRE SERVICE	6,035
		0
		0
		0
		19,394
7	OTHER	
	SCAVENGER	7,364
	SECURITY SERVICE	0
		7,364
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	14,000
		14,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	29,104
	LABORATORY & XRAY EXPENSE	177
	PURCHASED SERVICES	4,514
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	8,952
	PHARMACY CONSULTANT XVIII B 39-2	1,115
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,731
		0
		0
		45,593
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	3,572
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	298
		3,870
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	313
		313
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,046
		0
		3,046
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	58
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	61,488
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	7,678
	ADMINISTRATIVE CONSULTANTS XIX C	44,255
	PROFESSIONAL FEES XIX C	45,406
		0
20	FEES,SUBSCRIPTIONS,PROMOTIONS	97,339
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	15,068
	EMPLOYEE WANT ADS XIX F	69,390
	CONTRIBUTIONS VI 20 XIX F	3,042
	DUES & SUBSCRIPTIONS XIX F	4,431
	LICENSES & PERMITS XIX F	2,633
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	500
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	CLERICAL & GENERAL OFFICE EXPENSES	95,064
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,609
	EQUIPMENT REPAIR & MAINTENANCE	1,081
	OUTSIDE CLERICAL SERVICES	160,789
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	170
	TELEPHONE	17,678
		0
		183,327

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	196,008
	UNEMPLOYMENT COMPENSATION XIX D	26,966
	WORKERS COMPENSATION INSURANC XIX D	70,976
	HOSPITALIZATION INSURANCE XIX D	94,317
	EMPLOYEE BENEFITS - OTHER XIX D	8,192
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	5,995
	CHICAGO HEAD TAX XIX D	0
		402,454
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,040
		1,040
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	12,919
		0
		0
		12,919
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	74,313
		74,313
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	138,472
		138,472
27	OTHER	
	BAD DEBTS VI 24	9,465
		0
		9,465

GRAND TOTAL COLUMN 3 OTHER

1,299,223